PERSONAL HEALTH RECORD of (name) _____ **Age:** _____

Address: _____ **Phone#:** _____

E-Mail: _____ **Primary Language Spoken:** _____ **Date Record Updated:** _____

EMERGENCY CONTACT:	**HEALTH CARE PROXY 1:**	**HEALTH CARE PROXY 2:**
Name:	**Name:**	**Name:**
Phone#:	**Phone#:**	**Phone#:**
Relationship: ☐ Wife ☐ Son ☐ Husband ☐ Partner ☐ Daughter ☐ Other	**Relationship:**	**Relationship:**
PRIMARY DOCTOR:	**SPECIALIST DOCTOR:**	**OTHER DOCTOR:**
Name:	**Name:**	**Name:**
Phone#:	**Phone#:**	**Phone#:**
Date Last Seen:	**Date Last Seen:**	**Date Last Seen:**
	Reason:	**Reason:**

Name _____ **Primary Doctor** _____ **Phone#** _____

ALLERGIES:

- ☐ **NONE**
- ☐ Latex
- ☐ Bandaid Adhesive
- ☐ Medicine **(name)**

_____

_____

- ☐ Food **(name)**

_____

_____

- ☐ Insect **(name)**

_____

- ☐ Other **(name)**

_____

_____

HEALTH PROBLEMS:

- ☐ **NONE**
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Problem
- ☐ Breathing Difficulty
- ☐ COPD
- ☐ Cancer **(where)** _____
- ☐ Depression
- ☐ Diabetes (sugar in the blood)
- ☐ Heart Problems
- ☐ Hearing Problems
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Osteoporosis
- ☐ Seizures
- ☐ Thyroid Problem
- ☐ Other

_____

_____

_____

MEDICATIONS:

(Prescription, over the counter & Herbal)

Include Dose/Amount

(mg. Number of pill) /(# pills each day)

- ☐ **NONE**

HOSPITAL STAYS:

- ☐ **NONE**

Screening Tests (DATE)

Mammogram _____

PAP Smear _____

Prostate _____

Colonoscopy _____

Vaccines: (DATE)

Flu _____

Pneumonia _____

Tetanus _____

Diptheria _____

Do you have any problem with?

- ☐ **NONE**

Seeing _____

Hearing _____

Speaking _____